MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS
PROTOCOL

SUBJECT: Cleft Lip and/or Palate Repair APPLIES TO: MHP ☒ MLTCP ☒ MSSP ☐ HEALTHSELECT ☐	Protocol #: PA P150.03 Protocol Pages: 1 Attachments: Yes ☐ No ☒ Initial Effective Date: June 1999 Latest Review Date: May 2002

MIHS HEALTH PLANS APPROVALS:

Director, Medical Management:_____ Date:_____

Medical Director:_____ Date:_____

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Cleft Lip and/or Palate Repair.

PROTOCOL:

A. MHP and MLTCP with diagnosis and medical history refer to CRS Coordinator for review and for coverage by CRS.

B. The prior-authorization specialist may approve if the following is met:
   1. If CRS does not appropriately cover, Medical Director should review.

   2. Primary treatment is medically necessary for proper mastication, deglutition or phonation. Multiple-stage surgery will be approved if necessary to restore physiologic function.

C. Members over ten years of age will be reviewed by Medical Director.

D. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.

E. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage under the specific plan.

F. If requirements are not met, Medical Director review is required.